parts of the total SCIC adjustment determined at the end of the 60-day episode.

§ 484.240 Methodology used for the calculation of the outlier payment.

(a) CMS makes an outlier payment for an episode whose estimated cost exceeds a threshold amount for each case-mix group.

(b) The outlier threshold for each case-mix group is the episode payment amount for that group, the PEP adjustment amount for the episode or the total significant change in condition adjustment amount for the episode plus a fixed dollar loss amount that is the same for all case-mix groups.

(c) The outlier payment is a proportion of the amount of estimated cost beyond the threshold.

(d) CMS imputes the cost for each episode by multiplying the national per-visit amount of each discipline by the number of visits in the discipline and computing the total imputed cost for all disciplines.

(e) The fixed dollar loss amount and the loss sharing proportion are chosen so that the estimated total outlier payment is no more than 5 percent of total payment under home health PPS.

§ 484.245 Accelerated payments for home health agencies.

(a) *General rule.* Upon request, an accelerated payment may be made to an HHA that is receiving payment under the home health prospective payment system if the HHA is experiencing financial difficulties because there is a delay by the intermediary in making payment to the HHA.

(b) *Approval of payment.* An HHA's request for an accelerated payment must be approved by the intermediary and CMS.

(c) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(d) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as HHA bills are processed or by direct payment by the HHA.

§ 484.250 Patient assessment data.

An HHA must submit to CMS the OASIS data described at § 484.55(b)(1) and (d)(1) in order for CMS to administer the payment rate methodologies described in §§ 484.215, 484.230, 484.235, and 484.237.

§ 484.260 Limitation on review.

An HHA is not entitled to judicial or administrative review under sections 1869 or 1878 of the Act, or otherwise, with regard to the establishment of the payment unit, including the national 60-day prospective episode payment rate, adjustments and outlier payments. An HHA is not entitled to the review regarding the establishment of the transition period, definition and application of the unit of payments, the computation of initial standard prospective payment amounts, the establishment of the adjustment for outliers, and the establishment of case-mix and area wage adjustment factors.

§ 484.265 Additional payment.

QIO photocopy and mailing costs. An additional payment is made to a home health agency in accordance with § 476.78 of this chapter for the costs of photocopying and mailing medical records requested by a QIO.

[68 FR 67960, Dec. 5, 2003]

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

Subpart A [Reserved]

Subpart B—Conditions of Participation: Comprehensive Outpatient Rehabilitation Facilities

Sec.

Subparts C–E [Reserved]

Subpart F—Conditions of Participation: Critical Access Hospitals (CAHs)

Subpart G [Reserved]

Subpart H—Conditions of Participation for Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services

AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

SOURCE: 48 FR 56293, Dec. 15, 1982, unless otherwise noted. Redesignated at 50 FR 33034, Aug. 16, 1985.

Subpart A [Reserved]

Subpart B—Conditions of Participation: Comprehensive Outpatient Rehabilitation Facilities

§ 485.50 Basis and scope.

This subpart sets forth the conditions that facilities must meet to be certified as comprehensive outpatient rehabilitation facilities (CORFs) under section 1861(cc)(2) of the Social Security Act and be accepted for participation in Medicare in accordance with part 489 of this chapter.

§ 485.51 Definition.

As used in this subpart, unless the context indicates otherwise, *''comprehensive outpatient rehabilitation facility''*, *''CORF''*, or *''facility''* means a nonresidential facility that—

(a) Is established and operated exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons, at a single fixed location, by or under the supervision of a physician; and

(b) Meets all the requirements of this subpart.